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PLAGUE BEHIND GARRISON WALLS: SYPHILIS, GONORRHEA, AND REPRODUCTIVE HEALTH CRISES IN 19TH-CENTURY SULAWESI

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ABSTRACT
This article examines the venereal disease epidemic that swept through Sulawesi during the nineteenth century as a structural consequence of Dutch colonial military expansion. Drawing on colonial military medical reports, residency archives from Makassar and Manado, periodic medical journals, and missionary diaries, the study argues that the garrison complexes of the Koninklijk Nederlandsch-Indische Leger (KNIL) functioned as the primary epidemiological epicentres for the diffusion of syphilis (Treponema pallidum) and gonorrhoea (Neisseria gonorrhoeae) into civilian populations. Three interconnected processes are identified: first, the hyper-masculine demographic concentration within garrison walls that generated commercial and institutionalised sexual economies; second, the high spatial mobility of troops that transformed localised outbreaks into territory-wide transmission networks; and third, the systematic exclusion of indigenous women from meaningful therapeutic care. The evidence demonstrates that preantibiotic era infection produced a mass reproductive health crisis among local women, manifesting as secondary infertility, spontaneous abortion, stillbirth, and congenital syphilis. Colonial biopolitical responses compulsory registration, coercive hospitalisation, and mercury based treatment further imperilled women's bodies rather than safeguarding them. The article also recovers subaltern forms of resistance, including flight to the interior, bribery of health officers, and identity falsification, which challenged the colonial apparatus of bodily control.
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INTRODUCTION

The 19th century became a crucial landscape for the geopolitical and demographic transformation of the Sulawesi region. Through *the Koninklijk Nederlandsch Indische Leger* (KNIL), the colonial government of the Dutch East Indies aggressively strengthened its political hegemony from mere control of coastal areas to penetration into the

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interior (*binnenland*). The implications of this large-scale military expansion triggered unprecedented mass mobility on the island of Sulawesi. Waves of arrival of European soldiers, indigenous mercenaries from other regions, administrative employees, and cross-regional traders, were centered in major port cities such as Makassar, Manado, and Pare Pare (Dahlia et al., 2025). However, this military penetration not only brought with it a new bureaucratic order and socio-economic disruption for local communities, but also triggered a destructive public health crisis in the form of epidemics of venereal diseases (*venerische ziekten*), specifically *syphilis* (*Treponema pallidum*) and *gonorrhea (Neisseria gonorrhoeae*) (*Militair Geneeskundig Rapport 1872: Behandeling En Hospitalisatie van Venerisch Zieke Prostituées in Makassar En Manado*, 1872).

In the military environment of the 19th century, the presence of permanent bases, fortifications, and garrisons was the latent epicenter of the spread of sexually transmitted diseases. The dense barracks lifestyle, high levels of combat stress, lack of sanitation, and institutional policies that prohibited lowly soldiers from bringing legal wives, created fertile ground for a growing market for commercial sexual gratification around the garrison (Ramli et al., 2022). In Sulawesi, intense biological interactions between colonial soldiers and local women, both in the form of organized prostitution and the practice of barracks *concubinage*, made military complexes the main vector that spread pathogens from major ports to traditional enclaves in the interior. As a result, sexually transmitted infections quickly crept from behind the walls of military defenses and became an epidemic that infected the civilian population (Emalia, 2023).

Ironically, this *venereal* outbreak has a very unequal and destructive biological impact, especially for women in the lowest social strata who are in direct contact with the military ecosystem. In the absence of the invention of modern antibiotics such as penicillin, syphilis and gonorrhea triggered a massive reproductive health crisis among local women. The clinical manifestation of this chronic infection is manifested in the high rate of secondary *infertility* due to reproductive tract infections, spontaneous miscarriage (*abortion*), stillbirth, and transmission of congenital syphilis in the newborn. Indigenous women's bodies were not only physically damaged by the pathogen itself, but were also subjected to colonial toxic treatment trials using harmful substances such as mercury and mercury, which, instead of healing, accelerated organ failure and death (Ramadhan et al., 2026).

METHOD

This research uses a historical method with a qualitative approach through four main stages, namely heuristic, source criticism, interpretation, and historiography. The heuristic stage is carried out by collecting various primary and secondary sources that are relevant to reconstruct the epidemic of venereal diseases in Sulawesi in the 19th century. Primary sources used include the official colonial archives of the Nationaal Archief Den Haag and the National Archives of the Republic of Indonesia (ANRI), periodic medical documents such as *the Geneeskundig Tijdschrift voor Nederlandsch-Indië*, reports of the colonial Health Office, and missionary diaries. The analysis of these primary sources is enriched by a variety of secondary literature on colonial history, medical history, and gender history in Southeast Asia.

All the sources that have been collected then go through the source criticism stage, which includes external criticism and internal criticism. External criticism is carried out to test the authenticity, origin, and context of the production of documents, especially since most of the sources come from colonial institutions that had certain political and ideological interests. Internal criticism is directed at identifying biases, narratives, and knowledge constructions contained in colonial sources, especially related to the representation of indigenous women as objects of biopolitical surveillance. This approach allows researchers to read sources critically, not only as factual data, but also as products of colonial power relations.

The interpretation stage is carried out by integrating approaches to medical history, gender history, and colonial history. The medical history approach was used to understand the clinical aspects and treatment of sexually transmitted diseases in the 19th century, while the gender history approach examined the impact of epidemics on women and the

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position of women's bodies in colonial policies. A colonial historical approach is used to analyze the practices of surveillance, regulation, and community resistance to colonial health policies. The results of these interpretations are then compiled in the form of historiography that emphasizes the relationship between military expansion, the spread of venereal diseases, colonial biopolitical policies, and the experiences and resistance of indigenous women in 19th-century Sulawesi.

RESULT AND DISCUSSIONS

The establishment of permanent defensive posts and garrisons by *the Koninklijk Nederlandsch-Indische Leger* (KNIL) in Sulawesi in the second half of the 19th century drastically changed the spatial landscape and urban demographics. Military complexes such as Fort Rotterdam in Makassar and military bases in Manado were designed as centers of concentration of troops to secure maritime trade routes and dampen upheavals in the interior. However, behind their strategic function, these garrisons are an isolated and very dense ecosystem. Hundreds of soldiers from various ethnic backgrounds, both from European soldiers and indigenous soldiers (Javanese, Ambon, Madura) live side by side in military barracks with very minimal sanitation facilities. Humid environments, limited clean water, and poor air circulation are the causes of conditions that are susceptible to the transmission of various infectious diseases, including sexually transmitted diseases that are epidemic among the military (Report of the Civil Medical Service in the Dutch East Indies over the Year 1875, 1876; Setiawan et al., 2022; Stoler, 1991).

The masculine demographic density inside the fort led to extreme gender inequality in the area around the fort, which in turn led to the emergence of a market for service providers to meet the biological needs of soldiers. As the main instrument of the colonial government, the KNIL demanded a very high mobility of troops. Soldiers do not settle in one area, but continue to be mobilized across the geographical boundaries of Sulawesi to conduct military expeditions, territorial patrols, or rotations. This intensive spatial mobility is one of the main causes for the exponential spread of *venereal* pathogens (Sari et al., 2020). Soldiers who have been infected with syphilis or gonorrhea in a cosmopolitan port city such as Makassar, unknowingly carry the bacteria when sent to inland military posts in the residency area (Report About the Distribution from Venereal Diseases in the Port of Makassar , 1853).

The Military Medical Report (*Militair Geneeskundig Rapport*) of 1865 had noted a significant spike in cases of venereal disease among the military serving in *Celebes*, where military barracks were identified as a point of infection that continued to spread. The high movement pattern of troops is able to create several transmission networks that are no longer limited to urban localization, but rather spread to the traditional village areas around military crossings, undermining the defenses of local public health that were previously isolated from outside pathogens (Military Medical Report 1874: Incidents at the Facts of the Required Medical Research Te Makassar, 1874).

Concubinage and commercial sexual contact are major factors accelerating the transmission of pathogens in military environments. Another driver that made the spread of venereal diseases more widespread was the official policy of the colonial government regarding the restriction of legal marriage for lowly soldiers (Reid, 2014). Instead, the colonial government through military authority legalized or at least tolerated the practice of concubinage (*concubinage* or nyai) inside the barracks, in which local indigenous women were kept to serve the domestic and sexual needs of the soldiers. Beyond the conquest bonds of the barracks themselves, there was also an unorganized commercial prostitution ring that operated around the outer perimeter of the garrison walls (Martínez, 2016; Rules on the Registration and the Medical Supervision on the Public Women Te Makassar, 1864).

Sexual contact that occurs continuously and always changes partners between soldiers, mistresses, and commercial sex workers (PSK) creates an unbroken and continuous chain of transmission. These marginalized women, who were largely driven into prostitution due to structural poverty or the devastation of colonial wars, were the most vulnerable group to receive pathogen transfers from active-duty soldiers, making it a deadly health crisis

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around the Sulawesi garrison area (Military Medical Report on the Year 1865: Venereal Diseases Under the Troops in Celebe, 1865).

Another reality is that in the 19th century, when penicillin and antibiotics had not yet been invented, the impact of infection with the pathogens syphilis (*Treponema pallidum*) and gonorrhea (*Neisseria gonorrhoeae*) was already a terrible medical verdict and at the same time slowly but surely destroying the physical condition of the sufferer. Meanwhile, around the Sulawesi garrison area itself, the clinical manifestations of these two sexually transmitted diseases actually develop without effective therapeutic control. So that among local women who were infected and infected by the soldiers, the initial symptoms of gonorrhea were often not diagnosed quickly. This is due to the limited local medical knowledge, so that the infection creeps up and triggers acute pelvic *inflammatory disease* (Making et al., 2025; Zijlstra, 2025).

Meanwhile, syphilis itself develops in three destructive stages; which start from open wounds (*chancre*) on the reproductive organs, the appearance of skin rashes that spread throughout the body, to the tertiary stage that attacks the central nervous system can damage the skin and bone tissues of the sufferer, as well as trigger paralysis to insanity. Periodic reports from colonial civil health officials noted that the physical suffering experienced by marginalized women in port cities such as Makassar and Manado was exacerbated by the lack of access to proper medical care (The Treatment of Syphilis Met Quicksilver and Others Resources in Dutch-India: Experiences off Makassar in Manado, 1868; Verslag van Den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië over Het Jaar 1875, 1876).

The most traumatic impact of this venereal disease epidemic is the occurrence of a massive reproductive health crisis among the local female population. Untreated chronic gonorrhea infections result in blockages in the fallopian tubes, which massively increases the rate of infertility (secondary infertility) among former barracks mistresses and sex worker women. On the other hand, for women who manage to conceive, syphilis bacteria circulating in their blood penetrate the placenta and attack the developing fetus (Andaya, 2006, p. 205). This phenomenon causes high rates of spontaneous miscarriages (abortions), fetal death in the womb, and *stillbirths*. Meanwhile, babies who are successfully born alive often have congenital syphilis, which refers to a congenital defect condition characterized by damage to facial structures such as: saddle nose, bone abnormalities, blindness, and premature death within a few weeks after birth. This reproductive crisis not only destroys the biological future of individual women, but also creates a local demographic shock in the form of a decline in healthy birth rates in civilian settlements around military strongholds (Dharma, 2022; Report of the Civil Medical Service in the Dutch East Indies over the Year 1875, 1876).

In the midst of failing to stem the pace of the venereal disease epidemic, the colonial medical and military authorities launched a racially and gender-biased ideological narrative through a process of stigmatization. Instead of seeing indigenous women as victims of structural vulnerability and sexual exploitation of KNIL soldiers, the colonial medical community constructed indigenous women's bodies as the main "vector" or original source of all harmful pathogens in the transmission of sexually transmitted diseases. Local women were considered to have inferior morality and body anatomy that was susceptible to disease, thus labeled as a biological threat that could weaken the military power of the colonial government. This construction of stigma is strongly reflected in the contemporary records of the diaries of missionaries (*Zendeling*) in Makassar who observe how the discourse of religious morality combined with colonial medical stigma to further corner the social position of women in the lower layers (Military Medical Report 1872: Treatment And Hospitalisation from Venereal Sick Prostitutes in Makassar In Manado, 1872; Stoler, 1991). This scientific stigmatization was used by the colonial government to legitimize physical intervention and strict supervision of indigenous women's bodies in the name of saving the health of European soldiers as a defense against military members who were defense guards, especially the colonial government (Diary from Missionary H. van Den Brink Te Makassar, 1871–1878, 1878).

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When the venereal disease epidemic began to threaten the stability and combat efficiency of KNIL soldiers in Sulawesi, the colonial medical authorities attempted to implement various curative measures. However, due to the limitations of 19th-century medical science, the available treatment options are actually very destructive. The main treatment method adopted by the colonial government to deal with syphilis at that time was the use of a solution of heavy iron chemicals, especially mercury (*mercury*) and hydrargirum (*mercury dulcis* or mercury) (Sari et al., 2020). Indigenous women who are identified as sick are required to undergo this therapy, either through rubbing methods on the skin, pills, or fumenation (fuming). Instead of bringing healing, the toxic effects of mercury accumulation in the body of female patients trigger severe secondary suffering, such as salivary gland damage (acute salivation), tooth loss, gum decay, to kidney failure and premature death (Dahlia et al., 2025; Emalia, 2023). Medical documents published in the Geneeskundig Tijdschrift voor Nederlandsch-Indië confirm that colonial medical treatment in the Makassar and Manado regions at that time was still dominated by *trial and error* of toxic hard drugs, which placed the marginal female body as a testing laboratory (The Treatment of Syphilis Met Quicksilver and Others Resources in Dutch-India: Experiences of Makassar In Manado, 1868).

As a pillar of biopolitical policy enforcement, the colonial government established a special ward for venereal diseases (*venerische ziekenboeg*) which was integrated into military hospitals in Sulawesi. This mandatory quarantine system (*hospitalisatie*) is imposed coercion for every woman who is caught in a police raid and proven to have a sexually transmitted infection. However, instead of functioning as humanistic health care institutions, these quarantine barracks resemble repressive correctional institutions. Female patients are isolated from civilian society, confined to poorly sanitized rooms, and closely monitored by military guards to ensure they do not escape until they are declared clinically "clean or healthy" (Military Medical Report 1872: Treatment And Hospitalisation from Venereal Sick Prostitutes in Makassar In Manado, 1872; Military Medical Report 1874: Incidents at the Facts of the Required Medical Research Te Makassar, 1874).

An official report from *the Verslag van den Burgerlijken Geneeskundigen Dienst* shows that the main function of this isolation system was not a complete cure for the indigenous people, but rather a unilateral preventive measure by the colonial government in order to localize the pathogen from re-spreading into the barracks of European soldiers who held vital positions in the military structure of the colonial government. The coercive and gender-biased nature of colonial health regulations triggered a wave of rejection and latent resistance from the local female population in Sulawesi. One of the most hated policy instruments is the obligation to undergo periodic medical examinations (*geneeskundig onderzoek*) using speculum. For Bugis, Makassar, and Minahasa women, this medical procedure was perceived as a form of traumatic physical abuse as well as a gross violation of the boundaries of morality and the concept of local honor (Statistical Overview of The Medical Researched Prostitutes Te Makassar Over de Jaren 1870-1877, 1878). As a result, various resistance strategies emerged, namely; Starting from the act of fleeing to inland areas that were beyond the reach of colonial law, bribing the health service police, to falsifying registration identities. Police reports and residency records in Makassar and Manado document the numerous incidents of covert resistance as well as the tactical difficulties faced by colonial officials in enforcing the health isolation system, proving that local women's bodies refused to submit fully to the medical control established by the colonial government (Gritantin, 2022; Military Medical Report 1874: Incidents at the Facts of the Required Medical Research Te Makassar, 1874; *Politie-Rapport Over Ontduiking van de Verplichte Inschrijving*, 1881).

CONCLUSION

The epidemic of venereal diseases that hit Sulawesi in the 19th century was not a stand-alone medical phenomenon, but a public health crisis closely related to the expansion of the militaristic power of the Dutch colonial government. Based on the results of analysis of various medical documents and residency archives, it can be concluded

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that the fortresses and garrisons *of the Koninklijk Nederlandsch Indische Leger* (KNIL) in major port cities such as Makassar and Manado acted as the main epicenter of the spread of syphilis and gonorrhea pathogens. The high spatial mobility of soldiers between military posts and the legalization of *concubinage* practices in barracks have created an effective transmission network. This biological chain transferred *venereal diseases* from masculine colonial military spaces to traditional civilian settlements in the interior of Sulawesi. This sexually transmitted outbreak has had a very unequal and destructive physical impact on the local female population in the lowest social strata. Without access to modern antibiotics, chronic infections of gonorrhea and syphilis trigger a massive reproductive health crisis. The clinical manifestation of this pathogen is manifested in the high rate of infertility (secondary infertility) among former barracks women, as well as the surge in cases of spontaneous miscarriage, stillbirth, and congenital defects in the form of congenital syphilis in the babies who are born. Women's biological suffering is further exacerbated by the application of treatments based on heavy iron such as mercury and mercury, which instead of bringing healing, but often result in permanent organ damage to accelerate death for sufferers. The colonial government's response to this crisis confirmed the strong racial and gender bias in the colonial government's biopolitical policies. The military medical authorities refused to see indigenous women as victims of structural vulnerability, but instead constructed their bodies as "disease-spreading vectors" that threatened the work productivity of European military members belonging to the colonial government. Although the system of compulsory registration (*verplichte inschrijving*) and hospital quarantine (*hospitalisation*) was applied coerciously to control the local women's body, this mitigation met with major failures. This failure was not only caused by the limitations of medical science in the 19th century, but also by the latent resistance of Sulawesi women who carried out hidden resistance, which ranged from escaping to falsifying identities in order to maintain their bodily autonomy and refusing to submit to the forced control of the colonial government's medical institutions.

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